ILHIE ILLINOIS HEALTH INFORMATION EXCHANGE

ILHIE Direct Secure Messaging System
TEMPLATE CONSENT FORM

PATIENT INFORMATION			
NAME:	_____	ADDRESS:	_____
PHONE NUMBER:	_____		_____
E-MAIL ADDRESS:	_____	DATE OF BIRTH:	_____

I understand that by signing this form, I agree to allow my providers involved in my health care to talk to each other about my care and share my health information with each other to give me better care. My providers will use a secure messaging system called "ILHIE Direct". ILHIE Direct is a special e-mail system that allows providers to share my health information with each other securely via the Internet. ILHIE Direct meets the privacy and security standards of both The Health Insurance Portability and Accountability Act (HIPAA) and Illinois law.

I also understand that if I choose not to sign this form, none of my health information will be shared, and that my provider cannot condition my treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this form.

WHO MAY DISCLOSE. I authorize the following provider(s) to disclose my health information:
_____(*insert name of provider*)
_____(*insert name of provider*)
_____(*insert name of provider*)

WHAT MAY BE DISCLOSED. I authorize my provider named above to disclose all of my health care information including medications, immunizations, problems and diagnosis, demographic information, allergies, lab results, social history, psychiatric evaluations, my care plan, health care providers, presence and participation in substance abuse treatment or mental health services, HIV and genetic testing results.

_____ I wish to limit disclosure to the following: _____.

WHO MAY RECEIVE. I authorize my provider(s) named above to disclose this health information to (*insert name(s) of providers who can receive your information*):
_____
_____
_____
_____
_____

PURPOSES. I allow disclosure of my health information for purposes of □ treatment □ to coordinate care among my providers □ to improve my provider's health care operations.

EXPIRATION. This consent will expire one year from the date signed below or _____ (*insert exact date),* whichever is sooner.

REVOCATION. I can revoke my permission at any time by giving written notice to my provider except to the extent the disclosures I agreed to have already been acted on.

INSPECTION. I understand that I have a right to inspect and copy my health information.

10/31/12

FEDERAL LAW. The information that I consent to be disclosed may be from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further redisclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general consent for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Parent/Guardian or Personal Representative Date Authority to Act for Patient

_____ _____

Signature of Witness Date

THIS FORM MEETS ALL REQUIREMENTS OF THE FEDERAL CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS (42 C.F.R. PART 2), THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT (740 ILCS 110/5), AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) (45 CFR PARTS 160 AND 164).

TO BE COMPLETED BY OFFICE
_____ *Patient has received a copy of this signed Consent Form*

Prepared by Popovits & Robinson, P.C.
10/31/12